UnitedHealthcare Community Plan

Migraine Agents : Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist (Prophylaxis) - Washington

Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, have there been a reduction in headache days from baseline? ☐ Yes ☐ No

2. Indicate the patient's diagnosis:
   ☐ Migraine headaches* ☐ Episodic cluster headaches* ☐ Other. Specify: _____
   *As defined by the International Classification of Headache Disorders 3rd edition (ICHD-3)

3. Has prescriber ruled out medication overuse headache? ☐ Yes ☐ No

For the diagnosis of migraine headaches answer the following:

4. How many migraines per month does patient experience? _____

5. Indicate if patient has failed (defined as inability to reduce migraine headaches by two or more days per month) a 3-month trial from the following classes of preventative medications (check all that apply):
   ☐ Anticonvulsants: Topiramate or divalproex sodium
   ☐ Antidepressants. Venlafaxine, amitriptyline, or nortriptyline
   ☐ Beta-blockers. Propranolol, metoprolol, timolol or atenolol
   ☐ Contraindication/intolerance to treatments above. Explain: _____

6. Has patient received Botox (onabotulinum toxin) in the last 12 weeks? ☐ Yes ☐ No

7. Will this be used in combination with any other CGRP antagonists? ☐ Yes ☐ No

For the diagnosis of cluster headaches answer the following:

8. Has patient tried and failed any of the following (check all that apply):
   ☐ Verapamil, taking a total daily dose of at least 360mg for at least 1 month
   ☐ Verapamil is contraindicated. Explain _____

Provide the following with request:

Chart notes, including documentation of MIDAS or HIT6 testing

For reauthorizations:

For migraines, documentation of reduction of migraine days and severity of migraines

For cluster headaches, documentation of continued need for therapy and reduction in attacks

Prescriber signature	Prescriber specialty	Date